

<i>SERFF Tracking Number:</i>	<i>PRLD-126111771</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Principal National Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42116</i>
<i>Company Tracking Number:</i>	<i>TERM CONNECTOR/SN 23</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Term Life Insurance</i>		
<i>Project Name/Number:</i>	<i>Term Connector 2007/SN 23</i>		

Filing at a Glance

Company: Principal National Life Insurance Company

Product Name: Term Life Insurance

SERFF Tr Num: PRLD-126111771 State: Arkansas

TOI: L04I Individual Life - Term

SERFF Status: Closed-Approved-
Closed State Tr Num: 42116

Sub-TOI: L04I.103 Renewable - Single Life -
Fixed/Indeterminate Premium

Co Tr Num: TERM
CONNECTOR/SN 23

State Status: Approved-Closed

Filing Type: Form

Author: R Grubb

Reviewer(s): Linda Bird

Date Submitted: 04/15/2009

Disposition Date: 04/21/2009

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Term Connector 2007

Project Number: SN 23

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/21/2009

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 04/13/2009

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 04/21/2009

Created By: Carol Dewey

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: R Grubb

Filing Description:

New Submission - Individual Term Life

Term Life Insurance Policy SN 23

Data Pages SN 23-1

Enclosed for your approval are the forms listed above. These forms are new forms not replacing any previously approved forms for Principal National Life Insurance Company.

SERFF Tracking Number: PRLD-126111771 State: Arkansas
Filing Company: Principal National Life Insurance Company State Tracking Number: 42116
Company Tracking Number: TERM CONNECTOR/SN 23
TOI: L041 Individual Life - Term Sub-TOI: L041.103 Renewable - Single Life -
Fixed/Indeterminate Premium
Product Name: Term Life Insurance
Project Name/Number: Term Connector 2007/SN 23

Principal Financial Group has created a new sister company to Principal Life Insurance Company called Principal National Life Insurance Company (Principal National) to do business in 49 states and the District of Columbia, excluding the state of New York.

Eventually, Principal National will be the carrier for the new fixed life insurance product sales in the 49 states and District of Columbia. This current filing is for one of these products. Variable life products will be added to Principal National in the future.

This product and versions of these forms were previously filed and approved by your department for use by Principal Life Insurance Company and now we are filing the product and substantially similar forms in order that they may be used by Principal National Life Insurance Company.

Agents and brokers who are duly licensed by Principal National Life Insurance Company will market this individual life insurance product to individuals who have an existing 401(k) and/or a group insurance relationship with our Company. The policy will not be marketed with sales illustrations. The maximum policy issue ages vary by plan and range from 20 to 65. Coverage will be underwritten on a simplified issue basis. Previously approved application AA 3450 N, or previously approved applications AA 2000 N and AA 1800 N will be used to apply for this policy. In addition, previously approved Accelerated Benefits Rider, SN 3, will be used with this product.

SN 23, Term Life Insurance Policy: provides a level death benefit prior to the expiration date. Premium options include level premiums for a period of 10 or 20 years, with increasing premiums annually thereafter until the expiration date. Premiums are guaranteed for all policy years. The policy may be used on either a sex-distinct or unisex basis. The data pages will reflect the appropriate classification. The unisex rate basis will only be used when the policy is issued as part of an employee benefit plan under the Norris decision.

SN 23-1, Data Pages: are the data pages ("schedule pages") that will be used with policy form SN 23. The enclosed data pages provide sample data based on the insured and policyowner choices. A Statement of Variability describing policy specific and variable information is enclosed. We have bracketed the policy fee on the Data Pages as we reserve the right to change this item for new issues in the future within the range provided in the Statement of Variability. It is our understanding that a change to such bracketed item for future issues will not require a re-filing of the form. We have also bracketed the officers' signatures to allow for future changes without refiling the forms.

The forms enclosed for your review and approval are in final printed form, subject only to minor modification in format, paper size, stock, ink, border, company logo, and adaptation to computer printing. In addition, depending on printer capabilities, the forms may be printed either simplex or duplex.

If you have questions or would like more information, please contact me.

SERFF Tracking Number: PRLD-126111771 State: Arkansas

Filing Company: Principal National Life Insurance Company State Tracking Number: 42116

Company Tracking Number: TERM CONNECTOR/SN 23

TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: Term Life Insurance

Project Name/Number: Term Connector 2007/SN 23

Company and Contact

Filing Contact Information

Rosemary Grubb, Senior Analyst grubb.rosemary@prinipal.com
 711 High Street 800-255-6603 [Phone] 2 [Ext]
 Des Moines, IA 50392-0001 515-235-5494 [FAX]

Filing Company Information

Principal National Life Insurance Company CoCode: 71161 State of Domicile: Iowa
 711 High Street Group Code: 332 Company Type: Life, Health & Annuities
 Des Moines, IA 50392-0001 Group Name: State ID Number:
 (515) 246-7062 ext. [Phone] FEIN Number: 34-1022982

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: \$50 for forms and \$50 for rates = \$100
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Principal National Life Insurance Company	\$100.00	04/15/2009	27178211

<i>SERFF Tracking Number:</i>	<i>PRLD-126111771</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Company Tracking Number:</i>	<i>TERM CONNECTOR/SN 23</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Term Life Insurance</i>		
<i>Project Name/Number:</i>	<i>Term Connector 2007/SN 23</i>		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	04/21/2009	04/21/2009

<i>SERFF Tracking Number:</i>	<i>PRLD-126111771</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Product Name:</i>	<i>Term Life Insurance</i>		
<i>Project Name/Number:</i>	<i>Term Connector 2007/SN 23</i>		

Disposition

Disposition Date: 04/21/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	PRLD-126111771	State:	Arkansas
Filing Company:	Principal National Life Insurance Company	State Tracking Number:	42116
Company Tracking Number:	TERM CONNECTOR/SN 23		
TOI:	L04I Individual Life - Term	Sub-TOI:	L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name:	Term Life Insurance		
Project Name/Number:	Term Connector 2007/SN 23		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statement of Variability		Yes
Form	Term Life Insurance Policy		Yes
Form	Data Pages		Yes
Rate	Worksite Term Premium Rates		Yes

SERFF Tracking Number: PRLD-126111771 State: Arkansas

Filing Company: Principal National Life Insurance Company State Tracking Number: 42116

Company Tracking Number: TERM CONNECTOR/SN 23

TOI: L04I Individual Life - Term Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: Term Life Insurance

Project Name/Number: Term Connector 2007/SN 23

Form Schedule

Lead Form Number: SN 23

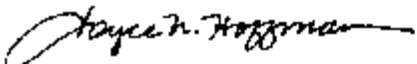
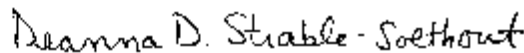
Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	SN 23	Policy/Cont Term Life Insurance ract/Fratern Policy al Certificate	Initial		51.000	SN23.pdf
	SN 23-1	Schedule Data Pages Pages	Initial		0.000	SN 23-1 10 year example - sex- distinct.pdf

TERM LIFE INSURANCE POLICY. Benefits are payable at the death of the Insured prior to the Policy Expiration Date and while this policy is in force. Premiums are level during the Initial Level Premium Period and increase annually thereafter until the Policy Expiration Date. Renewal premiums are payable during continuance of the policy. There is a conversion privilege as described in the policy. This policy is non-participating.

This policy is a legal contract between You, as owner(s), and Us, Principal National Life Insurance Company, a stock company. Your policy is issued based on the information in the application and payment of premiums as shown on the current Data Pages. We will pay the benefits of this policy in accordance with its provisions.

EXAMINATION OFFER. IT IS IMPORTANT TO US THAT YOU ARE SATISFIED WITH THIS POLICY. IF YOU ARE NOT SATISFIED, YOU MAY RETURN YOUR POLICY TO EITHER YOUR AGENT OR OUR OFFICE BEFORE THE LATER OF: (1) TEN DAYS AFTER YOU RECEIVE YOUR POLICY OR (2) SUCH LATER DATE AS SPECIFIED BY APPLICABLE STATE LAW. IF YOU RETURN YOUR POLICY, WE WILL REFUND ANY PREMIUM PAID AND YOUR POLICY WILL BE CONSIDERED VOID FROM ITS INCEPTION. PLEASE READ YOUR POLICY CAREFULLY SO YOU MAY BETTER USE ITS MANY BENEFITS.

This policy starts on the Policy Date and will stay in force until the earlier of the Policy Expiration Date shown on the Data Pages or death of the Insured so long as You satisfy the requirements outlined in Your policy.

 Senior Vice President and Corporate Secretary	 President
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**Principal National Life
Insurance Company**

711 High Street
Des Moines, Iowa 50392-0001

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A copy of the application and any additional benefits provided by rider follow the last page of this policy.

DEFINITIONS IN THIS POLICY

All of the following defined terms and phrases and certain items on Your Data Pages are capitalized throughout the policy. Please read them carefully as they will help You understand the policy provisions.

ATTAINED AGE is the Insured's Age on the birthday nearest to the Policy Date, plus the number of complete Policy Years that have elapsed since the Policy Date.

FACE AMOUNT is the amount used to determine the death benefit provided by the policy. The Face Amount is shown on the current Data Pages.

INITIAL LEVEL PREMIUM PERIOD is the number of Policy Years from the Policy Date during which the premium remains level. The Initial Level Premium Period is shown on the Data Pages.

INSURED is the person named as the Insured on the Data Pages of the policy. The Insured may or may not be the owner.

MONTHLY DATE is the day of the month which is the same as the day of the Policy Date. The Monthly Date will never be the 29th, 30th, or 31st of any month.

NOTICE is any form of communication We receive in Our Office providing the information We need, either in writing or another manner that We approve in advance.

OFFICE is Our home office.

POLICY DATE is the date from which Monthly Dates, Policy Years, and policy anniversaries are determined. The Policy Date is shown on the Data Pages. The Policy Date will never be the 29th, 30th, or 31st of any month.

POLICY YEAR is the one year period beginning on the Policy Date and ending one day before the policy anniversary and each subsequent one year period beginning on a policy anniversary.

Example: If the Policy Date is November 21, 2007, the first Policy Year ends on November 20, 2008. The first policy anniversary falls on November 21, 2008.

WE, OUR, US is Principal National Life Insurance Company.

YOU, YOUR is the owner(s) of this policy.

PURCHASING AND KEEPING THE POLICY IN FORCE

PREMIUM PAYMENTS

Your first premium is due on the Policy Date. After that, future premium due dates are determined by the frequency You select.

1. Annual premiums are due on the first day of each Policy Year.
2. Semi-annual premiums are due on the first day of each Policy Year and six months thereafter.
3. Quarterly premiums are due on the first day of each Policy Year and every three months thereafter.
4. Pre-authorized withdrawal premiums are due on the same day in each month as the Policy Date.

You may change the frequency of the premium payments with Our approval. However, if You choose a premium payment frequency other than annual, an additional charge, as shown on the current Data Pages, will apply over and above the guaranteed annual premium.

Premiums are payable when due. All premiums are to be sent to the address We provide in Your premium notice. We will give a receipt to You on request.

TABLE OF PREMIUMS

The guaranteed premium for each Policy Year is shown in the Table of Premiums on the Data Pages.

GRACE PERIOD

Except for the first premium, a grace period of 31 days will be allowed for the payment of each premium. The grace period begins when We mail a Notice of impending policy termination to You. If a premium is not paid when due or within the grace period, it is in default and the policy will terminate effective on the premium due date. We will mail a Notice of impending termination to Your last post office address known to Us.

If the Insured dies during a grace period, We will pay the death proceeds to the beneficiary(ies) subject to the Death Proceeds section of this policy.

TERMINATION

All Your policy privileges and rights under this policy terminate:

1. when the Insured dies; or
2. when the policy expires or is converted; or
3. when the grace period ends as described in the Grace Period provision; or
4. when We receive Your Notice to cancel it.

REINSTATEMENT

If Your policy terminates as described in the Grace Period provision, You may reinstate it provided:

1. Such reinstatement is prior to the Policy Expiration Date as shown on the Data Pages.
2. Not more than three years have elapsed since Your policy terminated.
3. You supply evidence which satisfies Us that the Insured is alive and insurable under Our underwriting guidelines then in effect. and
4. You pay all past due premiums. We reserve the right to charge interest on past due premiums at 6% compounded annually from their respective due dates.

Reinstatement will be effective on the Monthly Date on or next following the date We approve it. Your Policy Date will remain the original Policy Date. You will receive new Data Pages upon reinstatement.

RENEWAL PRIVILEGE

You may renew this policy without evidence of insurability for successive one year periods for the premium shown in the Table of Premiums on the Data Pages. No period of renewal may extend beyond the Policy Expiration Date shown on the Data Pages.

Renewal will be effective upon payment of the required premium on or before its due date or during the grace period.

CONVERSION PRIVILEGE

Subject to Our approval, this policy may be converted in whole or in part, without evidence of insurability, at any time before the Final Conversion Date shown on Your current Data Pages. The conversion will be allowed provided:

1. this policy is in force;
2. no premium is in default;
3. the Insured is not totally disabled; and
4. the Face Amount of the new policy does not exceed the Face Amount of this policy.

THE NEW POLICY

Premiums and values for the new policy will be based on:

1. a risk class most comparable to the risk class of this policy;
2. rates in effect on the date of the conversion; and
3. the Insured's Attained Age on the date of conversion.

The new policy will be any form of life insurance policy, except term insurance, available under Our underwriting guidelines then in effect. The period specified in the Suicide and Incontestability provisions will not begin again for the new policy, and will be measured from the Policy Date of this policy. If the new policy is not accepted, we will restore the Face Amount of Your policy to the Face Amount that existed prior to the conversion.

The date of conversion and the new policy's effective date of coverage will be the date We approve the Notice for conversion.

RIDERS

Any riders on this policy will cease upon conversion. Similar riders may be issued with the new policy without evidence of insurability subject to the provisions in the new riders and subject to Our rules in effect on the date of conversion. The following conditions must be satisfied:

1. the rider is included in this policy; and
2. the rider is available at the Attained Age of the Insured on the new policy's Policy Date.

DEATH PROCEEDS

We will pay the death proceeds to the beneficiary(ies) subject to the provisions of the policy, after We receive Notice and due proof that the Insured died while the policy was in force and prior to the Policy Expiration Date. We require notification of the Insured's death as soon as it occurs, or as soon thereafter as is reasonably possible. Proof of death includes documentation necessary to pay the death proceeds.

The death proceeds, determined as of the date of the Insured's death, will be:

1. the Face Amount of this policy as shown on the Data Pages; plus
2. the death proceeds from any benefit rider on the Insured's life; less
3. any pro rata premium due.

Any premium received after the date of death will be paid to the beneficiary(ies) and will not be included in the calculation of the death proceeds. The death proceeds will be determined without including any premium received after the date of death. With Our consent a different arrangement for return of premium may be specified prior to the payment of death proceeds.

We will pay interest on death proceeds as required by law.

BENEFIT PAYMENT OPTIONS

In lieu of a lump sum payment, You may elect a benefit payment option for payment of the death proceeds. If no benefit payment option has been elected before the Insured's death, the beneficiary may apply the death proceeds to a benefit payment option.

Once the proceeds are applied under a benefit payment option, this policy must be exchanged for a supplementary contract. The Company reserves the right, at its discretion, to provide a supplementary contract issued by itself, by an affiliated company, or by a non-affiliated issuer of annuity contracts.

BENEFIT PAYMENT CONDITIONS

Election of any benefit payment option is subject to the following conditions:

1. Any amount payable to an assignee will be paid in one lump sum. Any remaining proceeds will then be applied to the elected benefit payment option.
2. No changes may be made to the benefit payment option once a supplementary contract is issued.
3. The proceeds applied must be at least \$25,000.
4. Benefit payment options are restricted if the recipient of benefits is not a natural person.
5. We reserve the right to require evidence of age, gender where applicable, and continuing survival.
6. Under Options B, C, D, and E, one of the persons on whose life payments are based must be the owner, Insured, or beneficiary.

DESCRIPTION OF BENEFIT PAYMENT OPTIONS

OPTION A, CUSTOM: A custom benefit arrangement can be designed with the Company's written approval.

OPTION B, LIFE INCOME: We will make benefit payments during the person's lifetime. The minimum monthly life income is shown in the Option B Tables below. Payments cease when the person dies.

OPTION C, LIFE INCOME WITH GUARANTEED PERIOD: We will make benefit payments for the longer of the person's lifetime or a guaranteed period that You select. The guaranteed minimum monthly life income for an elected 10-year guaranteed period is shown in Option C Table below. If the person dies after payments begin but before the end of the guaranteed period, the remaining payments will be paid to the named beneficiary(ies) under the benefit payment option.

OPTION D, JOINT AND SURVIVOR LIFE INCOME: We will make benefit payments during the lifetime of two persons. The minimum monthly joint and 100% survivor life income is shown in the Option D Tables below. Payments cease when both persons have died.

OPTION E, JOINT AND SURVIVOR LIFE INCOME WITH GUARANTEED PERIOD: We will make benefit payments for the longer of the lifetimes of two persons or a guaranteed period that You select. The minimum monthly joint and 100% survivor life income for an elected 10-year guaranteed period is shown in the Option E Tables below. If both persons die after payments begin but before the end of the guaranteed period, the remaining payments will be paid to the named beneficiary(ies) under the benefit payment option.

BENEFIT OPTIONS B, C, D, and E: These benefit options are based on the Annuity 2000 Mortality Table with mortality projected 40 years by projection Scale G and 3% interest. Payments will be in an amount We determine but not less than guaranteed by this section. Benefit options are also based on the gender of the payee except for policies issued in states that require unisex tables or in connection with benefit plans not based on the gender of the Insured.

OPTION B TABLES

These tables show the minimum monthly life income for each \$1,000 of proceeds applied. We will make the first payment on the effective date of the supplementary contract.

Age of Male Payee	Life Income	Age of Female/Unisex Payee	Life Income
55	4.03	55	3.78
56	4.10	56	3.84
57	4.18	57	3.90
58	4.25	58	3.96
59	4.33	59	4.03
60	4.42	60	4.10
61	4.51	61	4.17
62	4.61	62	4.25
63	4.71	63	4.34
64	4.82	64	4.43
65	4.94	65	4.52
66	5.07	66	4.63
67	5.20	67	4.74
68	5.35	68	4.85
69	5.50	69	4.98
70	5.66	70	5.11
71	5.83	71	5.25
72	6.01	72	5.41
73	6.19	73	5.57
74	6.40	74	5.75
75	6.61	75	5.94
85	9.75	85	8.84
95	15.68	95	14.27

OPTION C TABLES

This table shows the minimum monthly life income for an elected 10-year guaranteed period for each \$1,000 of proceeds applied. We will make the first payment on the effective date of the supplementary contract.

Age of Male Payee	10-Year Guaranteed Period	Age of Female/Unisex Payee	10-Year Guaranteed Period
55	4.01	55	3.77
56	4.08	56	3.82
57	4.15	57	3.88
58	4.22	58	3.94
59	4.30	59	4.01
60	4.38	60	4.08
61	4.46	61	4.15
62	4.55	62	4.23
63	4.65	63	4.31
64	4.75	64	4.39
65	4.85	65	4.48
66	4.96	66	4.58
67	5.08	67	4.68
68	5.20	68	4.79
69	5.32	69	4.90
70	5.46	70	5.02
71	5.59	71	5.15
72	5.73	72	5.28
73	5.88	73	5.42
74	6.03	74	5.57
75	6.18	75	5.72
85	7.88	85	7.53
95	9.19	95	9.01

OPTION D TABLES

These tables show the minimum monthly joint and 100% survivor life income for each \$1,000 of proceeds applied. We will make the first payment on the effective date of the supplementary contract.

Age of Male Payee	Age of Female Payee							
	55	60	62	65	70	75	85	95
60	3.58	3.75	3.81	3.91	4.05	4.17	4.33	4.39
62	3.61	3.79	3.86	3.97	4.14	4.29	4.49	4.57
65	3.65	3.85	3.94	4.07	4.28	4.48	4.76	4.88
70	3.69	3.94	4.04	4.21	4.51	4.80	5.27	5.52
75	3.73	4.00	4.12	4.32	4.69	5.10	5.86	6.32
85	3.76	4.06	4.21	4.45	4.95	5.58	7.11	8.46
95	3.77	4.09	4.24	4.50	5.06	5.82	8.08	10.90

Age of Older Unisex Payee	Age of Younger Unisex Payee							
	55	60	62	65	70	75	85	95
60	3.53	3.67						
62	3.57	3.72	3.78					
65	3.61	3.79	3.86	3.97				
70	3.67	3.89	3.99	4.13	4.37			
75	3.71	3.97	4.08	4.27	4.60	4.94		
85	3.76	4.05	4.19	4.43	4.91	5.50	6.85	
95	3.77	4.08	4.23	4.50	5.05	5.79	7.94	10.46

OPTION E TABLES

These tables show the minimum monthly joint and 100% survivor life income for an elected 10-year guaranteed period for each \$1,000 of proceeds applied. We will make the first payment on the effective date of the supplementary contract.

Age of Male Payee	Age of Female Payee							
	55	60	62	65	70	75	85	95
60	3.58	3.75	3.81	3.91	4.05	4.17	4.31	4.37
62	3.61	3.79	3.86	3.97	4.14	4.29	4.47	4.54
65	3.65	3.85	3.94	4.07	4.28	4.47	4.73	4.83
70	3.69	3.93	4.04	4.21	4.50	4.78	5.22	5.41
75	3.72	3.99	4.11	4.31	4.68	5.08	5.76	6.10
85	3.76	4.05	4.20	4.44	4.92	5.51	6.79	7.62
95	3.77	4.07	4.22	4.48	5.01	5.69	7.38	8.70

Age of Older Unisex Payee	Age of Younger Unisex Payee							
	55	60	62	65	70	75	85	95
60	3.53	3.67						
62	3.57	3.72	3.78					
65	3.61	3.79	3.86	3.97				
70	3.67	3.89	3.98	4.13	4.37			
75	3.71	3.96	4.08	4.26	4.59	4.92		
85	3.75	4.05	4.19	4.42	4.89	5.44	6.60	
95	3.76	4.07	4.22	4.47	5.00	5.67	7.31	8.56

OWNER, BENEFICIARY, ASSIGNMENT

OWNER

The owner(s) is as named in the application unless You change ownership as provided in the Change of Owner Or Beneficiary provision. As owner(s), You may exercise every right and privilege provided by Your policy, subject to the rights of any irrevocable beneficiary(ies). Your ownership rights and privileges continue while Your policy is in force. If an owner dies before the policy terminates, the surviving owner(s), if any, shall succeed to that person's ownership interest, unless otherwise specified. If all owners die before the policy terminates, the policy will pass to the Insured. With Our consent You may specify a different arrangement for contingent ownership.

BENEFICIARY

The beneficiary(ies) named in the application will receive the death proceeds unless You change the beneficiary designation as provided in the Change of Owner Or Beneficiary provision. If any beneficiary dies before the Insured, We will pay the death proceeds to any surviving beneficiary(ies) according to terms of the beneficiary designation then in effect. If no beneficiary(ies) survives the Insured, the death proceeds will be paid to the surviving owner(s) in equal percentages or, if applicable, to the last surviving owner's estate unless otherwise specified.

If the beneficiary is not a natural person, We may require proof the beneficiary is a validly existing entity immediately prior to making payment but no later than 180 days following the death of the Insured. If proof cannot be provided, then the beneficiary(ies) will be deemed to NOT have survived the Insured's death.

CHANGE OF OWNER OR BENEFICIARY

You may change the owner(s) or beneficiary(ies) of this policy by sending Us Notice. Our approval is needed and no change is effective until We approve it. Once approved, the change is effective as of the date You signed the request. We may require that You send Us this policy so We can record the change.

BENEFIT INSTRUCTIONS

While the Insured is alive, You may send Us instructions for the payment of the death proceeds under one of the benefit payment options. Such instructions, or change of instructions, must be in a format We specify. We must approve the arrangement chosen before any payment is made. If You change beneficiary(ies), prior benefit instructions are revoked.

ASSIGNMENT

You may assign Your policy as collateral for a loan by providing Us with an original or a certified copy of the assignment which must be in a form acceptable to Us. We assume no responsibility for the assignment's validity. An assignment does not change the ownership of the policy. The rights of beneficiaries, whenever named, except for irrevocable beneficiaries named prior to Our notice of the assignment, become subordinate to those of the assignee. The assignment becomes effective on the date We receive it and is subject to any action taken by Us prior to that date.

GENERAL INFORMATION

ADJUSTMENTS

The policy Face Amount may be decreased as a result of a partial conversion. You may request a risk class change subject to Our underwriting guidelines then in effect.

THE CONTRACT

This policy, the attached application(s) and riders or endorsements, any amendments to the application(s), any adjustment and reinstatement application(s), and the current Data Pages make up the entire contract. Any statements made in the application(s), adjustment application(s), reinstatement application or any amendments to the application(s) will be considered representations and not warranties. No statement, unless made in an application(s), or amendments thereto, will be used to void Your policy (or void an adjustment in case of an adjustment application(s)) or to defend against a claim.

ALTERATIONS

This policy may be altered by mutual agreement, but any alterations must be in writing and signed by one of Our corporate officers. No one else, including the agent, may change the contract or waive any provisions.

INCONTESTABILITY

With respect to statements made in the initial application(s) for this policy, We will not contest this policy after the policy has been in force during the lifetime of the Insured for two years from the Policy Date. With respect to statements made in any subsequent application(s) or reinstatement application(s), We will not contest the coverage resulting from such application(s) after the coverage has been in force during the lifetime of the Insured for two years after the date of the change. The time limits in this Incontestability provision do not apply to fraudulent misrepresentations.

MISSTATEMENT OF AGE OR GENDER

If the age, or gender where applicable, of the Insured has been misstated, the death benefit will be the amount the premium would have purchased at the correct age, or gender where applicable, of the Insured.

SUICIDE

This policy's death proceeds will not be paid if the Insured dies by suicide, while sane or insane, within two years of the Policy Date. Instead, We will return all premiums paid. This amount will be paid to the beneficiary(ies).

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TERM LIFE INSURANCE POLICY. Benefits are payable at the death of the Insured prior to the Policy Expiration Date and while the policy is in force. Premiums are level during the Initial Level Premium Period and increase annually thereafter until the Policy Expiration Date. Renewal premiums are payable during continuance of the policy. There is a conversion privilege as described in the policy. This policy is non-participating.



Principal National Life
Insurance Company
Des Moines, Iowa 50392-0001

DATA PAGES

Term Life Insurance

POLICY DATA

Policy Number: [Sample] 1.
Owner(s): [John Doe] 2.
[Jane Doe]

For additional owners or subsequent ownership changes, see application or letter(s) of acknowledgement.

Insured's Name: [John Doe] 3.
Insured's Risk Class: [Standard Nontobacco] 4.
Insured's Age and Gender: [35 – Male] 5.

Policy Date: [May 1, 2009] 6.
Policy Expiration Date: [April 30, 2069] 7.

Face Amount: [\$25,000.00] 8.
Initial Level Premium Period: [10 years] 9.
Premium: [\$97.00] 10.
Premium Frequency: [Annual] 11.

Premiums after the Initial Level Premium Period are shown on page 3-1.

12.

If this policy is adjusted, We will send You new Data Pages. The Data Pages are to be attached to and made a part of this policy. Where new Data Pages conflict with previous Data Pages, the new Data Pages will govern.

Final Conversion Date: [April 30, 2019] 13.

TABLE OF PREMIUMS

Based on Policy Face Amount

Policy Year	Guaranteed Annual Premium	Policy Year	Guaranteed Annual Premium	Policy Year	Guaranteed Annual Premium
1	\$97.00	21	\$350.00	41	\$2,076.50
2	\$97.00	22	\$382.00	42	\$2,281.50
3	\$97.00	23	\$416.50	43	\$2,519.50
4	\$97.00	24	\$446.00	44	\$2,797.50
5	\$97.00	25	\$480.00	45	\$3,118.50
6	\$97.00	26	\$521.00	46	\$3,468.50
7	\$97.00	27	\$571.00	47	\$3,867.00
8	\$97.00	28	\$632.00	48	\$4,282.00
9	\$97.00	29	\$700.50	49	\$4,729.50
10	\$97.00	30	\$772.50	50	\$5,225.00
11	\$191.50	31	\$848.50	51	\$5,778.50
12	\$202.50	32	\$925.50	52	\$6,392.00
13	\$214.50	33	\$1,003.50	53	\$7,062.00
14	\$221.50	34	\$1,087.50	54	\$7,780.00
15	\$229.50	35	\$1,174.50	55	\$8,537.50
16	\$241.00	36	\$1,280.00	56	\$9,328.00
17	\$254.50	37	\$1,398.00	57	\$10,071.50
18	\$273.00	38	\$1,553.00	58	\$10,846.50
19	\$293.00	39	\$1,716.50	59	\$11,664.00
20	\$318.50	40	\$1,888.50	60	\$12,527.50

14.

Premiums for any additional riders attached to this policy will be in addition to the premiums shown above.

All premiums shown include an annual policy fee of: [\$75.00] **15.**

There is an additional charge for premium frequencies other than annual. This charge is based on the following premium frequency factors:

Semi-annual: .5125 of annual premium

Quarterly: .2625 of annual premium

Pre-Authorized Withdrawal: .0875 of annual premium

RIDER DATA

SERFF Tracking Number:	PRLD-126111771	State:	Arkansas
Filing Company:	Principal National Life Insurance Company	State Tracking Number:	42116
Company Tracking Number:	TERM CONNECTOR/SN 23		
TOI:	L04I Individual Life - Term	Sub-TOI:	L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name:	Term Life Insurance		
Project Name/Number:	Term Connector 2007/SN 23		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
	Worksite Term Premium Rates	SN 23	New		Final Worksite Term Premium Rates.pdf

Principal National Life Insurance Company
Policy Form # SN 23
Ten Year Term Product (2007)
Level Premium Rates per \$1000 (Years 1-10)
Add Annual Policy Fee of \$75

Issue Age	Male Std NT	Male Std Tob	Female Std NT	Female Std Tob
20	0.82	1.87	0.68	1.55
21	0.82	1.88	0.68	1.56
22	0.83	1.88	0.68	1.56
23	0.83	1.89	0.68	1.57
24	0.84	1.90	0.69	1.57
25	0.84	1.91	0.69	1.58
26	0.84	1.95	0.69	1.61
27	0.85	1.98	0.70	1.64
28	0.86	2.02	0.70	1.66
29	0.86	2.06	0.71	1.68
30	0.86	2.09	0.71	1.71
31	0.86	2.13	0.71	1.74
32	0.87	2.17	0.72	1.77
33	0.88	2.21	0.72	1.79
34	0.88	2.24	0.73	1.82
35	0.88	2.28	0.73	1.85
36	0.92	2.42	0.76	1.94
37	0.98	2.63	0.81	2.05
38	1.06	2.87	0.87	2.21
39	1.15	3.18	0.93	2.39
40	1.26	3.51	1.01	2.59
41	1.38	3.87	1.10	2.83
42	1.50	4.27	1.19	3.09
43	1.64	4.67	1.31	3.36
44	1.78	5.10	1.43	3.67
45	1.93	5.56	1.57	4.00
46	2.11	6.04	1.70	4.34
47	2.31	6.54	1.83	4.70
48	2.53	7.09	1.99	5.10
49	2.77	7.68	2.15	5.54
50	3.03	8.33	2.35	6.02
51	3.33	9.06	2.55	6.56
52	3.66	9.89	2.79	7.14
53	4.04	10.81	3.06	7.80
54	4.47	11.89	3.35	8.54
55	4.97	13.13	3.69	9.38
56	5.41	14.05	3.96	9.92
57	5.91	15.11	4.25	10.50
58	6.48	16.30	4.58	11.14
59	7.12	17.64	4.94	11.84
60	7.83	19.14	5.32	12.59
61	8.64	20.81	5.73	13.41
62	9.55	22.66	6.19	14.28
63	10.55	24.70	6.68	15.21
64	11.67	26.92	7.20	16.20
65	12.91	29.33	7.76	17.24

Principal National Life Insurance Company
Policy Form # SN 23
Twenty Year Term Product (2007)
Level Premium Rates per \$1000 (Years 1-20)
Add Annual Policy Fee of \$75

Issue Age	Male Std NT	Male Std Tob	Female Std NT	Female Std Tob
20	1.18	2.70	0.98	2.22
21	1.18	2.72	0.99	2.24
22	1.18	2.73	0.99	2.24
23	1.19	2.73	0.99	2.25
24	1.19	2.75	0.99	2.26
25	1.20	2.76	1.00	2.27
26	1.21	2.83	1.01	2.31
27	1.23	2.91	1.03	2.35
28	1.25	2.98	1.04	2.40
29	1.26	3.06	1.05	2.43
30	1.27	3.13	1.07	2.48
31	1.28	3.21	1.09	2.52
32	1.30	3.28	1.10	2.56
33	1.32	3.36	1.11	2.60
34	1.33	3.44	1.13	2.65
35	1.34	3.52	1.14	2.69
36	1.39	3.68	1.19	2.75
37	1.49	3.95	1.25	2.88
38	1.62	4.32	1.33	3.05
39	1.78	4.75	1.43	3.28
40	1.95	5.26	1.56	3.57
41	2.15	5.83	1.69	3.91
42	2.37	6.46	1.85	4.30
43	2.60	7.13	2.03	4.76
44	2.84	7.85	2.23	5.27
45	3.10	8.61	2.46	5.84
46	3.40	9.46	2.66	6.39
47	3.72	10.35	2.87	6.99
48	4.06	11.29	3.11	7.62
49	4.44	12.28	3.36	8.28
50	4.85	13.32	3.65	8.98
51	5.30	14.42	3.95	9.70
52	5.80	15.58	4.28	10.45
53	6.36	16.81	4.64	11.21
54	6.98	18.12	5.03	12.00
55	7.68	19.50	5.45	12.79
56	8.40	21.55	5.85	14.01
57	9.21	23.80	6.28	15.30
58	10.10	26.26	6.73	16.64
59	11.12	28.52	7.23	18.03
60	12.24	29.27	7.75	19.48

Principal National Life Insurance Company
Policy Form # SN 23
All Plans (2007)
Guaranteed Ultimate Premium Rates Per \$1000
(years 11+ for 10Y; 21+ for 20Y)
Add Annual Policy Fee of \$75

Attained Age	Male		Female	
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
30	2.04	3.60	1.28	2.06
31	2.02	3.60	1.36	2.24
32	2.02	3.64	1.44	2.38
33	2.08	3.74	1.52	2.56
34	2.12	3.88	1.64	2.78
35	2.18	4.00	1.78	3.06
36	2.30	4.22	1.90	3.30
37	2.40	4.46	2.06	3.58
38	2.58	4.80	2.14	3.76
39	2.74	5.14	2.26	4.00
40	2.92	5.54	2.40	4.24
41	3.16	6.06	2.54	4.52
42	3.46	6.66	2.70	4.86
43	3.80	7.38	2.90	5.26
44	4.20	8.24	3.14	5.72
45	4.66	9.14	3.42	6.26
46	5.10	9.98	3.74	6.86
47	5.58	10.92	4.14	7.62
48	5.86	11.44	4.58	8.56
49	6.18	12.04	5.06	9.62
50	6.64	12.90	5.62	10.78
51	7.18	13.92	6.24	12.04
52	7.92	15.32	6.94	13.42
53	8.72	16.90	7.70	14.88
54	9.74	18.88	8.50	16.48
55	11.00	21.12	9.36	18.16
56	12.28	23.40	10.36	19.96
57	13.66	25.82	11.40	21.88
58	14.84	27.72	12.52	23.74
59	16.20	29.92	13.64	25.80
60	17.84	32.58	14.80	27.94
61	19.84	35.88	16.06	30.16
62	22.28	39.86	17.44	32.66
63	25.02	44.28	18.86	35.16
64	27.90	48.80	20.40	37.80
65	30.94	53.26	22.10	40.68
66	34.02	57.56	23.98	43.74
67	37.14	61.74	26.04	47.18
68	40.50	66.14	28.34	50.96
69	43.98	70.50	30.86	55.06
70	48.20	75.78	33.64	59.64
71	52.92	81.56	36.84	64.86
72	59.12	89.42	40.42	70.62
73	65.66	97.32	44.30	76.82
74	72.54	105.30	48.56	83.62
75	80.06	114.58	53.28	90.46
76	88.26	124.46	58.46	97.92
77	97.78	135.88	64.16	105.94
78	108.90	149.08	70.46	114.58
79	121.74	164.10	77.26	123.92
80	135.74	180.14	84.86	133.98
81	151.68	198.10	95.18	148.14
82	168.28	216.22	106.82	163.52
83	186.18	235.22	118.42	178.50
84	206.00	255.88	131.24	194.60
85	228.14	280.18	145.68	210.82
86	252.68	306.78	158.78	224.34
87	279.48	335.38	178.50	245.78
88	308.20	365.44	199.10	267.18
89	338.50	396.54	221.06	288.70
90	370.12	428.26	241.30	306.10
91	399.86	456.86	251.54	309.88
92	430.86	486.04	271.68	325.32
93	463.56	516.20	301.56	350.20
94	498.10	547.48	339.28	381.94

<i>SERFF Tracking Number:</i>	<i>PRLD-126111771</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Principal National Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42116</i>
<i>Company Tracking Number:</i>	<i>TERM CONNECTOR/SN 23</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Term Life Insurance</i>		
<i>Project Name/Number:</i>	<i>Term Connector 2007/SN 23</i>		

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments:</p> <p>We certify that the forms in this submission meet the provision of Rule and Regulation 19 regarding unfair sex discrimination in the sale of insurance, as well as all applicable requirements of the Department.</p> <p>We have reviewed our issue procedures and assure you that we are in compliance with and provide the Life and Health guaranty notice required by Regulation 49.</p> <p>We have reviewed our procedures and assure you that we are in compliance with and provide the notice required by Arkansas Code Ann. 23-79-138.</p> <p>Attached is the certification of compliance with Arkansas Rule and Regulations 33 and 34 along with the Consent to Submit Rates along with a readability certificate.</p> <p>Attachments:</p> <p>AR Readability cert.pdf</p> <p>SN 23_AR Rates certification.pdf</p>		
<p>Satisfied - Item: Application</p> <p>Comments:</p> <p>Attached are the applications that will be used with the submitted policy. These applications were approved by your department on 10-24-2008.</p> <p>Attachments:</p> <p>AA3450N.pdf</p> <p>AA2000N.pdf</p> <p>AA1800N.pdf</p>		

	Item Status:	Status Date:
<p>Satisfied - Item: Statement of Variability</p>		

<i>SERFF Tracking Number:</i>	<i>PRLD-126111771</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Principal National Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42116</i>
<i>Company Tracking Number:</i>	<i>TERM CONNECTOR/SN 23</i>		
<i>TOI:</i>	<i>L04I Individual Life - Term</i>	<i>Sub-TOI:</i>	<i>L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium</i>
<i>Product Name:</i>	<i>Term Life Insurance</i>		
<i>Project Name/Number:</i>	<i>Term Connector 2007/SN 23</i>		

Comments:

The Statement of Variability for SN 23-1 is attached.

Attachment:

Statement of Variability.pdf



ARKANSAS CERTIFICATION

PRINCIPAL NATIONAL LIFE INSURANCE COMPANY

RE: SN 23, et al

This is to certify that the submitted forms have achieved a Flesch Reading Ease Score as noted below and comply with the requirement of Arkansas Statute Annotated 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Form No.</u>	<u>Score</u>
SN 23	51

A handwritten signature in black ink, appearing to read "Jeff Hostetter", written over a horizontal line.

Jeff Hostetter
Assistant Director, Individual Product Management

Date: 04/15/09



Principal National Life Insurance Company
Des Moines, IA 50392-1170

ARKANSAS

CONSENT TO SUBMIT RATES

The Principal National Life Insurance Company ("Company") of Des Moines, Iowa, does hereby consent and agree that all premium rates and/or cost bases both "maximum" and "current or projected," used in relation to policy form number SN 23 must be filed with the Insurance Commissioner for the State of Arkansas ("Commissioner") at least sixty (60) days prior to their proposed effective date. Such rates and/or cost bases shall be deemed effective sixty (60) days after they are filed with the Commissioner; unless the Commissioner shall approve or disapprove such rates and/or cost bases prior to the expiration of sixty (60) days.

Date: April 15, 2009

Signature: 

Title: Associate Actuary - Pricing

Name: Bryce Rosel, FSA, MAAA



☐ Principal Life Insurance Company
☐ Principal National Life Insurance Company
Members of Principal Financial Group®

P.O. Box 10431
Des Moines, IA 50306-0431

**Worksite Term
Life Insurance
Application**

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

1. PERSONAL INFORMATION ABOUT THE PROPOSED INSURED

Name (First, Middle, Last)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Primary Residence Street Address	Social Security Number - -	Birthplace (State, or Country if not U.S.)
City, State, Zip Code	Driver's License Number	State Issued
Home Phone Number ()	Occupation	Annual Income
Work Phone Number ()	Workplace Zip Code	

2. TERM COVERAGE APPLIED FOR

Product _____	Policy Planned Premium \$ _____
Face Amount \$ _____	Premium Frequency: (choose one) <input type="checkbox"/> EFT* <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi Annual <input type="checkbox"/> Annual

***Authorization for Withdrawals and/or Electronic Funds Transfer:** By providing my financial institution name and account information, I hereby authorize the Company to debit my checking/savings account as needed to pay premiums. Notification of cancellation of this authorization must occur within 10 working days of the transaction by the party canceling the authorization.

Financial Institution Name	Financial Institution Phone Number ()
Financial Institution Address	Account Holder's Name
Transit and Routing Number	Account Number

☐ Checking (attach a voided check) ☐ Savings (attach a deposit slip)

3. BENEFICIARY INFORMATION

Primary Beneficiary	Relationship to Proposed Insured
Contingent Beneficiary	Relationship to Proposed Insured

4. OWNERSHIP INFORMATION (If other than Proposed Insured)

Owner Name	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth
Contingent Owner Name	Relationship to Proposed Insured

5. OTHER INSURANCE

Is there other life insurance or annuities in force or applied for? ☐ Yes ☐ No
If yes, list total amount of life insurance and total amount of annuities in force or applied for. _____

Proposed Insured Name _____

6. REPLACEMENT

Will the insurance applied for with this application replace or affect any of the owner's other life or annuity contracts (including pending coverage provided with a binding receipt)? ☐ Yes ☐ No

If yes, list company name(s) and policy number(s) and provide necessary forms. _____

7. ACTIVELY AT WORK

Are you actively at work full time (30 hours or more per week) at your usual place of business on the date this application is signed with no more than 3 consecutive days missed in the past 180 days because of medical reasons such as illness or injury? ☐ Yes ☐ No

If no, please explain

8. TOBACCO USE

Within the past 24 months, have you used any form of tobacco products? ☐ Yes ☐ No
If yes, provide details

MEDICAL HISTORY/HEALTH HABITS (Provide details to yes answers, questions 10-14 below)

9. Current Height _____ Weight _____

10. In the last five years, have you been convicted of driving while intoxicated or reckless driving?..... ☐ Yes ☐ No

11. In the last five years, have you received treatment because of your alcohol or drug use or been advised by a medical professional to decrease alcohol or drug use? ☐ Yes ☐ No

12. In the last ten years, have you had, been treated for or been diagnosed as having HIV (Human Immunodeficiency Virus) infection, positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)? ☐ Yes ☐ No

13. In the last ten years, have you had, been treated for or been diagnosed as having any of the following? (If yes, check all that apply): ☐ Yes ☐ No

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lupus | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hodgkin's Disease | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Ulcerative Colitis |

14. In the last ten years, have you consulted a doctor, been hospitalized, used any prescription medication for six months or longer, or sought medical advice for any illness or injury not provided in response to a previous question? ☐ Yes ☐ No

DETAILS TO QUESTIONS 10-14

[illegible]

AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

AGREEMENT

Statements In Application: I represent that all statements in this application are true and complete to the best of my knowledge and belief and were correctly recorded before I signed my name below. I understand and agree that the statements in the application shall be the basis of any insurance issued. I also understand that misrepresentations can mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

I understand that the policy(ies) delivered to me may be from a different issuer than what was listed in the application. I understand and agree that my acceptance of the policy(ies) shall be considered an amendment to this application. Each policy has only one issuing company and that issuer is solely responsible for the obligations under that policy.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

When Policy Coverage Becomes Effective: I understand and agree that if a policy is issued, policy coverage will become effective as of issuance. The Company agrees to pay any proceeds pursuant to policy terms subject to the acceptance of the proposed owner.

Limitation of Authority: I understand and agree that no agent, broker, or licensed representative has any authority to determine insurability, or to make, change or discharge any contract, or to waive any of the Company's rights.

AUTHORIZATION

I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution or person having personal information (including physical, mental, drug or alcohol use history) regarding me, the named proposed insured, to provide to the Company, its representatives or reinsurers, any such data. I authorize the Company or its representative to conduct a telephone interview in connection with my application for insurance.

I authorize the Medical Information Bureau (MIB, Inc.) to furnish the above data to the Company, its representative or its reinsurers. I authorize the Company or its representative to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct or update previously supplied data to the MIB, Inc. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I agree that this authorization shall be valid for 24 months from the date of this application. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree a photocopy of this authorization is as valid as the original. I have received a copy of this authorization. I have received a copy of the "Notice of Insurance Information Practices," which includes notice required by any Fair Credit Reporting Act. It also describes MIB, Inc.

Advance Premium Paid: I have paid an advance premium with this application and I have been given the Life Insurance Conditional Receipt. In return I have read, understand, and agree to its terms.

Owner Taxpayer Identification Number Certification: As proposed owner of this contract, I certify under penalties of perjury: (1) The taxpayer identification number shown on this application is correct, (2) I am not subject to IRS backup withholding, and (3) I am a U.S. person (which includes a U.S. resident alien). If subject to backup withholding complete W-9. If not a U.S. person complete W-8. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Signatures – Please read all of the above Agreements, Authorizations, and Certification before signing below.

Signature of Proposed Insured X	Signature of Owner, if other than Proposed Insured, and Title X	
Signed at: City	State	Date

Producer Section

Do you know, or have reason to believe, replacement is or may be involved in this transaction? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Signature of Licensed Agent/Broker/Representative X	Date	License Number
Cosignature by resident Licensed Agent/Broker/Representative, if applicable X	Date	License Number



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**Worksite Term
Life Insurance
Application**

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

AGREEMENT

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I understand that the policy(ies) delivered to me may be from a different issuer than what was listed in the application. I understand and agree that my acceptance of the policy(ies) shall be considered an amendment to this application. Each policy has only one issuing company and that issuer is solely responsible for the obligations under that policy.

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When Policy Coverage Becomes Effective: I understand and agree that if a policy is issued, policy coverage will become effective as of issuance. The Company agrees to pay any proceeds pursuant to policy terms subject to the acceptance of the proposed owner.

Limitation of Authority: I understand and agree that no agent, broker, or licensed representative has any authority to determine insurability, or to make, change or discharge any contract, or to waive any of the Company's rights.

AUTHORIZATION

I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution or person having personal information (including physical, mental, drug or alcohol use history) regarding me, the named proposed insured, to provide to the Company, its representatives or reinsurers, any such data. I authorize the Company or its representative to conduct a telephone interview in connection with my application for insurance.

I authorize the Medical Information Bureau (MIB, Inc.) to furnish the above data to the Company, its representative or its reinsurers. I authorize the Company or its representative to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct or update previously supplied data to the MIB, Inc. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

I agree that this authorization shall be valid for 24 months from the date of this application. I may revoke this authorization for information not then obtained. Such revocation must be in writing. It will not be effective until received at the Company's Home Office. I agree a photocopy of this authorization is as valid as the original. I have received a copy of this authorization. I have received a copy of the "Notice of Insurance Information Practices," which includes notice required by any Fair Credit Reporting Act. It also describes MIB, Inc.

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Life Insurance
Conditional
Receipt

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

Name of Proposed Insured(s)	Advance payment of: \$	Date of Application:
-----------------------------	---------------------------	----------------------

(In this Receipt, "we", "us", "our", or "the Company" is Principal Life Insurance Company) is the Company which issues the policy, Principal Life Insurance Company or Principal National Life Insurance Company, respectively.

AUTHORITY:

This Receipt is not a "binder." No agent, broker, or licensed representative may accept risks, determine insurability or bind the Company in any way. No agent, broker, or licensed representative may waive or change any terms of the Receipt, or of the policy(ies) applied for, or any other rights of the Company. The agent, broker, or licensed representative has **NO AUTHORITY** to accept any premium or to issue this Receipt: if it is apparent that any **Condition Precedent** to coverage under this Receipt is not or cannot be satisfied. **This Conditional Receipt shall be ineffective if issued without authority. Only the Home Office, and not the agent, broker, or licensed representative, has authority to modify any provisions of this Receipt.**

TERMS AND CONDITIONS:

The Company will pay a death benefit to the beneficiary named in the Application if the proposed insured dies while this Conditional Receipt is in effect, subject to the terms and conditions set out below.

1. CONDITIONS PRECEDENT: All the following conditions must be fulfilled exactly. Otherwise there is **NO insurance under this Receipt and the Receipt is void:** (a) On the Start Date, the Proposed Insured must be living and insurable, as determined by our underwriters under our underwriting guidelines. If a condition affecting such insurability existed in fact on the Start Date, it shall be considered in the determination of insurability; and (b) The premium deposit must be at least one full month's premium for each policy applied for; and (c) This Receipt must be issued at the same time as the application; and (d) The premium deposit must be received in our Home Office and must be honored on first presentment for payment.

2. AMOUNT OF COVERAGE: The amount of insurance provided by this Receipt shall be that applied for on the Application, subject to all the **LIMITATIONS** set forth in this Receipt, and will be the lesser of: (a) The amount of all death benefits applied for in the Application; or (b) \$200,000.

This total death benefit limit applies to all insurance applied for under this and any current Applications to the Company and any other Conditional Receipts that may be in effect with us.

3. DATE COVERAGE BEGINS: If all of the **Conditions Precedent** set forth in this Receipt are fulfilled exactly, insurance under this Receipt takes effect on the **Start Date**. The Start Date is the date upon which all of our initial Application requirements are completed. Our initial Application requirements consist of full completion and signing of the Application.

4. DATE COVERAGE ENDS: Any insurance provided by this Receipt ends on the **Stop Date**, which is the **earliest** of: (a) 75th day after the Start Date; or (b) the date we mail the proposed owner a premium refund and a notice that no policy will be issued on the Application; or (c) when policy coverage becomes effective.

5. HEALTH AND INSURABILITY: This Receipt does not commit us to issue any policy. However, in determining whether to issue this policy and on what terms, we will consider no changes in a Proposed Insured's health or insurability occurring between the Start Date and the Stop Date. We have until policy coverage becomes effective to make this determination.

6. LIMITATIONS: (a) Our Liability: Except as limited by this Receipt, our liability is governed by the terms of the policy(ies) applied for; and (b) Suicide: No death benefit is payable under this Receipt if the Proposed Insured dies by suicide while sane or insane. In such case, our sole liability shall be to pay the premium we received to the named beneficiary(ies); and (c) Misrepresentation: No benefit is payable under this Receipt and this Receipt is void, if there is any incorrect, untrue, incomplete, or omitted statement of material fact in the Application. No knowledge of any fact on the part of any agent, broker, licensed representative, or other person shall be considered knowledge of the Company unless such fact is stated in the Application; and (d) Other: If any provision of this Receipt is unenforceable under state law, all other terms and conditions shall continue in full force and effect.

7. DEATH PROCEEDS: If an event giving rise to a claim occurs at any time before the Stop Date of this Receipt, coverage will be considered solely under this Receipt even if a policy is issued. If an event giving rise to a claim occurs at any time after the Stop Date of this Receipt but before policy coverage becomes effective, then the Company shall incur no liability under the Receipt or the Policy even if a policy is issued.

8. PREMIUMS: If a policy is issued from the Application bearing the same date listed on this Receipt and is accepted by the proposed owner, we will apply the premium deposit to the first premium due for such policy. If no policy is put into force but a benefit is paid under this Receipt, we will keep the premium deposit. If no policy is put into force and no benefit is paid under this Receipt, the premium deposit will be refunded. **ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY AS INDICATED ON PAGE ONE OF THE APPLICATION – DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE CHECK PAYEE BLANK.**



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**Life Insurance
Application**

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PART A

1. PERSONAL INFORMATION ABOUT THE PROPOSED INSURED

Name (First, Middle, Last)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /	
Primary Residence Street Address	Social Security Number - -	Birthplace (State, or Country if not U.S.)	
City, State, Zip Code	Driver's License Number	State Issued	
Home Phone Number ()	Occupation		
Work Phone Number ()	Workplace Zip Code		

2. BASIC COVERAGE APPLIED FOR

Product _____	Policy Planned Premium \$ _____
Face Amount (excluding riders) \$ _____	Premium Frequency: (choose one) <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Single Pay
Death Benefit Option if applicable: <input type="checkbox"/> Option 1: Level Face Amount <input type="checkbox"/> Option 2: Face + Accumulated/Policy Value <input type="checkbox"/> Option 3: Face + Premiums Paid Less Partial Surrenders	<input type="checkbox"/> EFT (complete EFT form + attach sample check) List Bill Number _____ <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly Unscheduled Premium \$ _____

3. BENEFITS/RIDERS (Some riders are not available with all products)

<input type="checkbox"/> Accidental Death – Amount \$ _____	<input type="checkbox"/> Policy Split Option
<input type="checkbox"/> Accounting Benefit	<input type="checkbox"/> Salary Increase – Amount \$ _____
<input type="checkbox"/> Alternate Cash Surrender Value	<input type="checkbox"/> Single Life Term – Amount \$ _____
<input type="checkbox"/> Change of Insured	<input type="checkbox"/> Waiver of Premium/Specified Premium
<input type="checkbox"/> Children Term – Amount \$ _____	<input type="checkbox"/> Waiver of Monthly Deductions/Monthly Policy Charges
<input type="checkbox"/> Four Year Term	<input type="checkbox"/> _____
<input type="checkbox"/> 20 Year Premium Guarantee	<input type="checkbox"/> _____

4. BENEFICIARY INFORMATION

Primary Beneficiary	Relationship to Proposed Insured
Contingent Beneficiary	Relationship to Proposed Insured
Single Life Term Rider Beneficiary	Relationship to Proposed Insured

Proposed Insured Name _____

5. OWNERSHIP INFORMATION (Complete if different than the Insured)

Owner Name (If trust, provide name of trust*)	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth (If trust, provide date of trust*)
Joint Owner Name	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth
Contingent Owner Name	Relationship to Proposed Insured

* Submit copy of trust with this application.

6. CHANGE OF OWNERSHIP

- (a) Is there an intention that any group of investors will obtain any right, title, or interest in any policy issued on the life of the Proposed Insured(s) as a result of this application?..... ☐ Yes ☐ No
If yes, explain. _____
- (b) Will you borrow money to pay the premiums for this policy or have someone else pay these premiums for you in return for an assignment of policy values back to them? ☐ Yes ☐ No
If yes, explain and complete premium financing acknowledgment form. _____

7. OTHER INSURANCE

- (a) Is there other life insurance or annuities in force or applied for? ☐ Yes ☐ No
(If yes, list all other life insurance or annuities in force or currently being applied for, even if sold, assigned, or viaticated.)

Insured's Name	Company	Amount	Policy Number	Check if Pending	Year Issued	Primary Purpose
		\$		<input type="checkbox"/>		
		\$		<input type="checkbox"/>		
		\$		<input type="checkbox"/>		
		\$		<input type="checkbox"/>		

- (b) If coverage is pending, will all pending coverage be accepted? ☐ Yes ☐ No
If no, explain. _____
- (c) Have you transferred or assigned any right, title, or interest in any life insurance or annuity contract other than absolute assignment for Internal Revenue Code 1035 exchange? ☐ Yes ☐ No
If yes, explain. _____

8. REPLACEMENT

- (a) Will the insurance applied for with this application replace or affect any of the owner's other life or annuity contracts (including pending coverage provided with a binding receipt)? ☐ Yes ☐ No
If yes, list company name(s) and policy number(s) and provide necessary forms: _____

- (b) Is this an Internal Revenue Code section 1035 exchange? ☐ Yes ☐ No

Proposed Insured Name _____

9. MEDICAL QUESTION

Within the last ten years, has the Proposed Insured been treated for, or diagnosed as having a heart condition, chest pain, stroke, cancer, diabetes, alcohol abuse or drug dependency?..... ☐ Yes ☐ No
(If yes, explain below.)

Details (including dates and healthcare provider's name/address)

[illegible]

(Continue to next page)



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Des Moines, IA 50306-0431

Life Insurance
Application

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PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

AGREEMENT

Statements In Application: I represent that all statements in this application are true and complete to the best of my knowledge and belief and were correctly recorded before I signed my name below. I understand and agree that the statements in the application, including statements by the Proposed Insured in any medical questionnaire that becomes a part of this application, shall be the basis of any insurance issued. I also understand that misrepresentations can mean denial of an otherwise valid claim and rescission of the policy during the contestable period.

I understand that the policy(ies) delivered to me may be from a different issuer than what was listed in the application. I understand and agree that my acceptance of the policy(ies) shall be considered an amendment to this application. Each policy has only one issuing company and that issuer is solely responsible for the obligations under that policy.

When Policy Coverage Becomes Effective: I understand and agree that if a policy is issued as applied for with a premium deposit paid, policy coverage will become effective as of issuance. The Company agrees to pay any proceeds pursuant to policy terms subject to the acceptance of the proposed owner and signing of Part D, if applicable.

I understand and agree that if a policy is issued as other than applied for or without a premium deposit (C.O.D.), then policy coverage is not effective and the Company shall incur no policy liability unless:

- 1) A policy issued on this application has been physically delivered to and accepted by the owner and the first premium paid; and
- 2) At the time of such delivery and payment, the person to be insured is actually in the state of health and insurability represented in this application, medical questionnaire, or amendment that becomes a part of this application; and
- 3) The Part D or the Acknowledgment of Delivery form is signed by me and the Proposed Insured (if different than me) and dated at delivery.

If these conditions are met, the policy is deemed effective on the Policy Date stated in the policy data pages.

Limitation of Authority: I understand and agree that no agent, broker, licensed representative, telephone interviewer, or medical examiner has any authority to determine insurability, or to make, change or discharge any contract, or to waive any of the Company's rights. The Company's right to truthful and complete answers to all questions on this application and on any medical questionnaire that becomes a part of this application may not be waived. No knowledge of any fact on the part of any agent, broker, licensed representative, telephone interviewer, medical examiner or other person shall be considered knowledge of the Company unless such fact is stated in the application.

If my employer is the owner and beneficiary on this application: I agree to allow my employer to purchase insurance on my life. I understand that my employer or trustee will have all present and future rights of ownership and will also be the beneficiary of the policy. There is no obligation, on my part, to pay the policy premiums. I acknowledge that as an employee, the employer or trustee has an insurable interest in my life. I understand and agree that my administrators, estate, heirs and assignees have no rights to the policy or any policy proceeds. I understand that the maximum face amount for which I could be insured at the time of issuance is generally not more than 30 times compensation, up to a maximum of \$30,000,000, subject to underwriting guidelines. I further authorize my employer or trustee to increase or decrease the amount of insurance on my life in the future without another consent from me and without further notice to me as long as I am employed by the employer. I consent to and authorize my employer, trustees, or its successors to continue to be the owner and beneficiary of this policy(ies) indefinitely including after the end of my employment by the employer.

AUTHORIZATION

I authorize any insurance (or reinsuring) company, consumer reporting agency, governmental agency, insurance agent, broker, licensed representative, or any other organization, institution or person having personal information (including physical, mental, drug or alcohol use history) regarding me, the named proposed insured, to provide to the Company, its representatives or reinsurers, any such data. I authorize the Company or its representative to conduct a telephone interview in connection with my application for insurance.

I understand and agree to sign any authorization that is required to authorize any doctor, hospital, clinic, health care provider, laboratory, pharmacy benefit manager or any other institution having personal information (including physical, mental, drug or alcohol use history) regarding the named proposed insured to provide the Company, its representatives or reinsurers any such data. I understand that if I refuse to sign an authorization to release my complete medical record, the Company may not be able to process my application for life insurance coverage.

PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (CONTINUED)

I authorize the Medical Information Bureau (MIB, Inc.) to furnish the above data to the Company, its representative or its reinsurers. I authorize the Company or its representative to release any such data to MIB, Inc. or as required by law. Notwithstanding any other provision in this form, the authorization to release data to the MIB, Inc. shall survive the termination of this form to the extent necessary to confirm, correct or update previously supplied data to the MIB, Inc. Data released may include results of my medical examination or tests requested by the Company. I understand that the data obtained by use of this authorization will be used by the Company to determine eligibility for insurance.

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- ☐ This application is C.O.D. and I have not been given any Conditional Receipt with this application.
- ☐ I have paid \$ _____ as an advance premium with this application which is no less than one month's advance premium and I have been given the Life Insurance Conditional Receipt. In return I have read, understand, and agree to its terms.
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OWNER TAXPAYER IDENTIFICATION NUMBER CERTIFICATION: As proposed owner of this contract, I certify under penalties of perjury: (1) The taxpayer identification number shown on this application is correct, (2) I am not subject to IRS backup withholding, and (3) I am a U.S. person (which includes a U.S. resident alien). If subject to backup withholding complete W-9. If not a U.S. person complete W-8. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Signatures – Please read all of the above Agreements, Authorizations, and Certification before signing below.

Signature of Proposed Insured (If age 15 or over)				
X				
Signature of Parent (If Proposed Insured is under age 18 and Parent has not signed as Owner)				
X				
Signature of Owner(s), if other than Proposed Insured. If corporation, an officer other than the Proposed Insured must sign and include officer's title. If joint ownership or Trust, all joint owners/trustees must sign. If signing as a Trustee include 'Trustee' as title.				
X			Title	
X			Title	
X			Title	
Signed at: City	State	Date	Signature of Licensed Agent/Broker/Representative	License Number
			X	
Cosignature by resident Licensed Agent/Broker/Representative, if applicable in your state			Date	License Number
X				



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I understand and agree to sign any authorization that is required to authorize any doctor, hospital, clinic, health care provider, laboratory, pharmacy benefit manager or any other institution having personal information (including physical, mental, drug or alcohol use history) regarding the named proposed insured to provide the Company, its representatives or reinsurers any such data. I understand that if I refuse to sign an authorization to release my complete medical record, the Company may not be able to process my application for life insurance coverage.

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PART C – AGREEMENT/AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (CONTINUED)

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- ☐ I have submitted an Absolute Assignment form with this application and I have been given the Life Insurance 1035 Conditional Receipt. In return I have read, understand, and agree to its terms.

Warning: It is a crime to provide false, misleading, or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

OWNER TAXPAYER IDENTIFICATION NUMBER CERTIFICATION: As proposed owner of this contract, I certify under penalties of perjury: (1) The taxpayer identification number shown on this application is correct, (2) I am not subject to IRS backup withholding, and (3) I am a U.S. person (which includes a U.S. resident alien). If subject to backup withholding complete W-9. If not a U.S. person complete W-8. **The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

CLIENT COPY



Principal Life Insurance Company
Principal National Life Insurance Company
Members of Principal Financial Group®

P.O. Box 10431
Des Moines, IA 50306-0431

**Insurance
Application**

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

Proposed Insured _____
D.O.B. ____ / ____ / ____ Policy Number (If known) _____

PART B

All references to "you" mean the Proposed Insured.

ACTIVITIES/HEALTH HABITS

1. In the last five years have you, or do you have plans to:
 - a. be a member of any armed forces or military unit? ☐ Yes ☐ No
 - b. pilot any type of aircraft? ☐ Yes ☐ No
 - c. engage in scuba/skin diving, motor vehicle racing, skydiving or any other hazardous sporting activity? ☐ Yes ☐ No
 - d. live outside the United States or Canada? (If yes, explain below) ☐ Yes ☐ No
 - e. travel outside the United States or Canada? (If yes, explain below) ☐ Yes ☐ No
2. In the last five years have you:
 - a. been in a motor vehicle accident, been charged with driving while intoxicated or had more than one moving violation? (If yes, explain below) ☐ Yes ☐ No
 - b. been on parole or probation or charged with a felony or misdemeanor? (If yes, explain below) ☐ Yes ☐ No
3. In the last ten years have you used any tobacco or nicotine products? ☐ Yes ☐ No
(Indicate date last used and amount per day)
 - a. ☐ cigarettes _____
 - b. ☐ cigars _____
 - c. ☐ nicotine patch/gum _____
 - d. ☐ pipe _____
 - e. ☐ chewing tobacco/snuff _____
 - f. ☐ other _____
4. In the last ten years have you consumed alcoholic beverages? ☐ Yes ☐ No
If yes, date last used? _____ Number of drinks per week: _____
5. In the last ten years have you used cocaine, marijuana, methamphetamines, barbiturates or other controlled substances? ☐ Yes ☐ No
6. Have you ever been advised to limit or discontinue the use of alcohol or drugs; or sought or received treatment because of your alcohol or drug use? ☐ Yes ☐ No

DETAILS TO QUESTIONS 1-6

Quest. #	Include dates and details as requested above.



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Proposed Insured _____
D.O.B. ____ / ____ / ____ Policy Number (If known) _____

PART B – (Continued)

INCOME/OCCUPATION

For Life, complete questions 7 and 8. For DI, complete questions 8-17. In all cases, Part B continues on the next page.

7. Annual income from occupation \$ _____ Other Income \$ _____
Source of other income _____ Net Worth (Assets – Liabilities) \$ _____
8. Primary occupation _____ Employer _____
9. Current Employment Information
a. Type of business or industry _____
b. Job title _____
c. What are your job activities and percentage of time spent in each? _____

d. How many hours do you usually work per week in your primary job? _____
e. Total number of employees: Full-time _____ Part-time _____ Sub-contracted _____
f. How many employees do you supervise? _____
10. How long have you been employed by your current employer? _____ (If less than three years, provide details below, e.g., employers, occupations and dates for last five years.)
11. Do you work out of your home? (If yes, how many hours per week? _____) ☐ Yes ☐ No
12. Do you have any other part-time or full-time jobs? (If yes, explain below) ☐ Yes ☐ No
13. Are you actively at work on a full-time basis without medical restriction?
(If no, explain below) ☐ Yes ☐ No
14. Do you intend to change jobs or employment in the next 6 months? (If yes, explain below) ☐ Yes ☐ No
15. Have you ever requested or received any type of disability benefits (including workers' compensation and state disability) for an injury or illness? (If yes, explain below) ☐ Yes ☐ No
16. Do you have an ownership interest in any business you work for? ☐ Yes ☐ No
If yes, ownership percentage _____ length of ownership _____
Type of business: ☐ C Corporation ☐ S Corporation ☐ Partnership
☐ Sole Proprietorship ☐ Limited Liability Company ☐ Other _____
17. Have you, or any business owned in whole or part by you, ever been in bankruptcy or any similar proceedings? (If yes, provide date discharged, type and chapter) ☐ Yes ☐ No

DETAILS TO QUESTIONS 7-17

Quest. #	Include dates and details as requested above.



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Proposed Insured _____
D.O.B. ____ / ____ / _____ Policy Number (If known) _____

PART B – (Continued)

MEDICAL HISTORY (Provide details to yes answers, questions 18-20 below)

18. In the last ten years, have you had, been treated for or been diagnosed as having:
- a. high blood pressure, heart attack, chest pain, heart murmur, irregular heart beat, stroke, or any other disease or disorder of the heart or blood vessels? ☐ Yes ☐ No
 - b. cancer or a tumor, cyst or growth? ☐ Yes ☐ No
 - c. asthma, bronchitis, emphysema, tuberculosis or any other disease or disorder of the lungs or respiratory system? ☐ Yes ☐ No
 - d. seizure, paralysis, headaches, multiple sclerosis or any other disease or disorder of the brain or nervous system? ☐ Yes ☐ No
 - e. chronic fatigue, stress, depression, anxiety or any other emotional or psychological disorder? ☐ Yes ☐ No
 - f. hepatitis, colitis, ulcer, cirrhosis, irritable bowel or any other disease or disorder of the liver, gallbladder, pancreas or digestive tract? ☐ Yes ☐ No
 - g. diabetes, borderline diabetes, sugar in the urine, thyroid disorder or any other disease or disorder of the glandular system? ☐ Yes ☐ No
 - h. kidney stones, nephritis, any blood or protein in the urine, sexually transmitted disease, prostate disorder, breast disorder or any other disease or disorder of the urinary or reproductive system? ☐ Yes ☐ No
 - i. back or neck pain, disc problems, spinal sprain or strain, sciatica, arthritis, carpal tunnel syndrome, or any other disease or disorder of the bones, joints, or muscles? ... ☐ Yes ☐ No
 - j. any disease or disorder of the eyes, ears, nose, throat or skin? ☐ Yes ☐ No
19. (DI Only) Are you currently pregnant or have you had complications of pregnancy in the last ten years? ☐ Yes ☐ No
20. In the last ten years, have you had, been treated for or been diagnosed as having HIV (Human Immunodeficiency Virus) infection, positive HIV (Human Immunodeficiency Virus) test or AIDS (Acquired Immunodeficiency Syndrome)? ☐ Yes ☐ No

DETAILS TO QUESTIONS 18-20

Quest. #	For yes answers, include dates, details, diagnosis, types and results of treatment, healthcare provider's full name and address.



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Proposed Insured _____
D.O.B. ____ / ____ / ____ Policy Number (If known) _____

PART B – (Continued)

MEDICAL HISTORY (Provide details to yes answers, questions 21-26 below)

21. Who is your Primary Physician? ☐ None
- | a. Name | Phone Number |
|---------|----------------|
| _____ | _____ |
| Street | City State Zip |
| _____ | _____ |
- b. Date last seen, reason and details

22. In the last ten years:
- a. have you had any medical tests, hospitalization, illness or injury not provided in response to a previous question? (If yes, explain below) ☐ Yes ☐ No
- b. have you consulted a doctor, chiropractor, psychiatrist, psychologist, counselor, therapist or other healthcare provider not provided in response to a previous question? (If yes, explain below) ☐ Yes ☐ No
23. Are you taking or have you been advised to take any medication or treatment not provided in response to a previous question? (If yes, explain below) ☐ Yes ☐ No
24. Current Ht. _____ Wt. _____ Have you lost more than 10 lbs. in the last year? ☐ Yes ☐ No
If yes, _____ lbs./kgs. Indicate reason _____
25. a. Has either of your natural parents lived to at least age 60? ☐ Yes ☐ No
b. Do any of your natural parents or siblings have a history of diabetes, cancer, stroke or heart disease? ☐ Yes ☐ No
If yes, provide details (i.e., relationship, type of disease, age diagnosed, current age or age at death):

26. Have you ever had any life, health or disability insurance rated, ridered or declined? (If yes, explain below) ☐ Yes ☐ No

DETAILS TO QUESTIONS 21-26

Quest. #	Include dates and details as requested above.

**Statement of Variability
SN 23-1**

The variability for bracketed items in the above-referenced form is provided below. This Statement of Variability reflects bracketing of items that will vary based upon policy specific information. In addition, this Statement of Variability also reflects bracketing of the policy fee that Principal National Life Insurance Company might vary within the range provided for future issues without requiring a re-filing. Any change made to such item will be determined based on sound actuarial practice and administered in a uniform and non-discriminatory manner. Such variable information will not be changed for issued policies, only for new issues.

Page 3

1. Prints policy number.
2. Prints owner's name(s).
3. Prints insured's name.
4. Prints insured's risk class.
5. Prints insured's age and gender (if unisex rate basis, prints 'unisex').
6. Prints Policy Date.
7. Prints Policy Expiration Date based on insured's attained age 95.
8. Prints the policy Face Amount.
9. Prints the Initial Level Premium Period: 10 years or 20 years
10. Prints the Premium at issue.
11. Prints premium frequency at issue.
12. The following line prints on an adjustment data page:

Adjustment Date:

[Date]

13. Prints Final Conversion Date based on the earlier of the insured's attained age 70 or the level premium period.

Page 3-1

14. Applicable premium rates print here.
15. The company may revise the annual policy fee for future issues within the following range: \$50 thru \$150.

Page 3-2

Rider Data Page:

Prints Rider information.